HealthPAC
Health Program of Alameda County

TREATMENT EXCEPTION REQUEST
FOR PROVIDER USE ONLY (PLEASE PRINT CLEARLY)
Please Fax Completed Form to HealthPAC HIV at 510-567-6850
TELEPHONE: 510-383-1790

*PATIENT INFORMATION:

LAST NAME FIRST NAME

_____

Patient's ADAP ID Date of Birth

Most Recent Viral Load test/date:_____

Most Recent CD4 Count/date:_____

Current Weight:_____Current Height:_____

Previous Weight:_____Date:_____

*DIAGNOSIS DESCRIPTION:
(ICD-9 CM Code Plus Description)

_____

_____

*MEDICAL JUSTIFICATION:

_____

_____

_____

_____

*PHARMACY INFORMATION:

Pharmacy Name NABP#

_____

Phone Number Fax Number

*PHYSICIAN INFORMATION:

_____

Last Name First Name

_____

Phone Number Fax Number

_____

DEA Number E-Mail address

_____

Address City Zip Code

Signature of pharmacist or physician Date

_____

DRUGS REQUESTED (ADAP FORMULARY MEDICATIONS ONLY):

GENERIC NAME	NDC CODE	DIRECTIONS	QUANTITY

REQUEST: ☐APPROVED AS REQUESTED ☐APPROVED AS MODIFIED ☐DENIED
COMMENTS:

ALAMEDA HEALTHPAC HIV RX USE ONLY

AUTHORIZATION VALID FROM: ____/____/_____ TO ___/____/_____ BY:_____DATE:_____
☐LONG TERM AUTHORIZATION ☐PRIOR AUTHORIZATION REQUIRED FOR EACH FILL
NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ADAP ELIGIBILITY. BE SURE PATIENT'S ELIGIBILITY IS CURRENT BEFORE DISPENSING DRUG.

Ramsell